NoHLA Comments on Washington Churn Issues and Options – IHPS presentation 5/3/12

Northwest Health Law Advocates

General Comments

1. We distinguish two types of churn: program churn and health plan churn. The IHPS analysis only looks at health plan churn.

- Program churn involves transitions in eligibility and enrollment that cause gaps in coverage and loss of coverage. As we know, program churn can occur both within a program (e.g., gap in coverage if a recertification is not completed in time, perhaps due to difficulty obtaining verification) and when someone is moving between programs (e.g., a gap in coverage when transitioning from Medicaid to the Exchange, or a big increase in cost of health coverage when moving from Medicaid to the Exchange or ESI).

- Health plan churn involves people moving between health care systems as a result of changes in program (Medicaid to Exchange) or type of coverage (individual to employer-sponsored insurance). This occurs when the person's insurance carrier from the old program does not participate in the new program.

2. There are a number of options to address program churn. We provide these in a separate document. If adopted, we think they would significantly decrease the number of people who go "back and forth" between Medicaid and the Exchange/BH/ESI. Addressing program churn issues comprehensively would result in a much smaller health plan churn problem, because anyone who retains program eligibility does not experience health plan churn.

3. The Basic Health option under the ACA is a general approach to preserving continuity of coverage that has great value in preventing churn. Urban Institute research shows that BH implementation will reduce churning between Medicaid and the Exchange by 16%.

4. The IHPS analysis does not consider the group of Medicaid clients who are offered employer-sponsored insurance (ESI). However, this needs to be taken into account in assessing health plan churning between Medicaid and the Exchange because these people are not permitted to go to the Exchange if they have affordable ESI offers. Some Medicaid clients already have ESI and then experience an increase in income. Others may become ineligible for Medicaid due to increased income or hours of employment, which is frequently accompanied by an offer of ESI. The ideas in the IHPS paper only address people moving to and from the Exchange, not people moving from Medicaid to ESI or ESI to Medicaid. For ESI folks moving out of Medicaid, the best ways to reduce plan churn are to provide (1) premium assistance to Medicaid enrollees with ESI, and (2) Transitional Medical Assistance (TMA) for one year after the person becomes Medicaid eligible, if TMA continues to be available after 2013.

5. Recognizing that it's inevitable that some churning will occur, it would also be important to consider what measures could be taken to assure clinical continuity of care as people change plans.

Slide-by-slide

Slide	Comment
4	It would be helpful to show Medicaid pregnant women at 185% FPL.
5	We suggest including a definition of "churn" as used in this paper (i.e., health plan churn). We suggest adding a column for ESI
7	The note says it is limited to those without ESI. It would be helpful to include information about what % of enrollees have ESI/offers of ESI at various income levels.
8-9	A Basic Health program would address this problem. Urban Institute has findings on churn with and without a BH program.
10, 25	We support a continuous enrollment approach – 1115 waiver is required
13-14	Medicaid to Exchange continuity (limited participation): this sounds like a good idea if permitted by the federal government. A BH option would raise the income level and might partially address the "depleted resources" problem.
15	Limits would add complexity – the state would essentially be creating a mini-program with its attendant eligibility, process and notice obligations. This in itself could create "program churn." Equity issue: would you also allow person to stay with plan if transitioning to ESI? How would payment work in that situation?
16	Allow continued enrollment only while income remains less than 200% FPL. Again, why not use BH option here?
20	Exchange to Medicaid continuity: This may be a non-starter with QHPs as they would not want to take Medicaid capitated payments. Another way to do this is with Medicaid premium assistance and wraparound.
22	Limits would add complexity, cost and churn issues of their own. See comment re slide 15.
25	Continuous eligibility is a good idea. What is the basis for projecting a 70%-80% increase in member-months? How much of this could be offset by savings on the Exchange subsidies? There would also be large administrative savings and plan savings.
27	Whole family coverage: problem. We are not aware of evidence that there is an adverse impact when parents and children are covered in separate plans rather than the same plan, although it can be more convenient. The biggest advantage of "whole family" coverage is probably that parents need to learn just one plan's procedures for accessing care and pay a single premium bill. But the trade-off suggested of limiting children's coverage is troubling. The state should not roll back children's coverage in this way for the sake of perceived convenience for the family. Also, most parents at CHIP income levels are offered ESI that disqualifies them from subsidies in the Exchange, so they would be in a different plan from a child in a QHP.
29	This scenario involves parents choosing lesser coverage for their child at higher cost than available through CHIP. The full EPSDT range of

	coverage would not be available, and the ACA does not permit tax credits or cost-sharing subsidies since the child is CHIP eligible. As a result, CHIP dollars, with the usual federal-state split, would need to pay for everything not financed by the family. If QHPs pay commercial reimbursement, that is likely to cost many more state dollars per capita than are currently paid to the Healthy Options plans. In doing work for California, the Urban Institute found that furnishing CHIP kids with CHIP-level benefits and cost-sharing protections using commercial networks would raise state costs by 75%, requiring a new funding source. For families, the out-of-pocket costs per family could be prohibitive, especially for children with special healthcare needs. By contrast, the current program has minimal premiums and no other cost-sharing.
32	If Medicaid/CHIP is financing the whole family QHP coverage for a child, we think it would need to be equivalent benefits and cost-sharing to that of a child on Medicaid/CHIP. In other words, Medicaid/CHIP law, including EPSDT, would apply to kids financed by the program.
33	We have concerns about the ability of the state to get a waiver such as this under the ACA. It would result in much higher costs to the federal government to subsidize the child through tax credits. Again, there is a risk of significant cost-sharing to the family.
36	Pregnant women – a question: how many prenatal providers in Washington state participate in Medicaid? If the proportion is high, the "churn" would not be as big an issue.
39	The potential solution involves using federal Medicaid funds to supplement federal tax credits/cost-sharing subsidies in the Exchange, but the ACA states that a person eligible for Medicaid may not receive Exchange subsidies. State funds would need to pay the costs of supplementing QHP coverage. Basic Health would seem to be a much better approach because it is entirely federally funded and allows women to keep the same benefits and cost-sharing protections when they become pregnant.
41-42	Continuity and BHP – Allowing QHPs to participate in BHP on a limited basis is a good idea. Section 1331(e)(2) of the ACA prohibits eligible individuals from using the Exchange, so it would be important to determine how QHPs could actually participate in the state BHP.
43-45	We are not as concerned about the effect of income tax reconciliation on federal payments. We don't yet know how HHS will interpret section 1331 of the ACA. And we think it's likely that the state could avoid the adverse effects of reconciliation. This is because if income drops, reconciliation will increase federal BHP payments, without the kind of caps that apply to reductions in federal BHP payments when income rises. The state can further minimize the level of reconciliation payments by promptly reviewing income changes.

May 11, 2012